Provider Evaluation of Performance (PEP) plan and audit tools

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United Healthcare®

UnitedHealthcare Community Plan – Behavioral Network Services

Clinical Record Tool – Applied Behavioral Analysis

Facility name: _____

Reviewer name: _____

Patient gender: _____

Patient age: _____

Primary diagnosis: _____

Date of facility review: _____

Rating scale: NA = Not applicable Y = Yes N = No			Y	N	NA
General documentation standards					
UnitedHealthcare Administrative Guide	**1**	Each client has a separate record.			
Comments:					
UnitedHealthcare Administrative Guide	**2**	Each record includes the client's address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.			
Comments:					
UnitedHealthcare Administrative Guide	**3**	All entries in the record include the responsible service provider's name, professional degree and relevant identification number, if applicable, and dated and signed where appropriate.			

General document standards			Y	N	NA
Comments:					
UnitedHealthcare Administrative Guide	**4**	The record is clearly legible to someone other than the writer.			
Comments:					
UnitedHealthcare Administrative Guide	**5**	There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the client and/or legal guardian.			
Comments:					
UnitedHealthcare Administrative Guide	**6**	There is documentation that the service provider provides education to client/family about service planning, discharge planning, supportive community services, behavioral health problems and care options.			
Comments:					
UnitedHealthcare Administrative Guide	**7**	There is documentation that the risks of noncompliance with treatment recommendations are discussed with the client and/or family or legal guardian.			
Comments:					

Initial assessment			Y	N	NA
UnitedHealthcare Administrative Guide	**8**	An initial primary treatment diagnosis is present in the record, including who gave the diagnosis, and any diagnostic report leading up to the ASD diagnosis.			
Comments:					
UnitedHealthcare Administrative Guide	**9**	There is evidence of a functional behavioral assessment in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**10**	Prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.			
Comments:					
UnitedHealthcare Administrative Guide	**11**	Each record includes a description of specific levels of behavior at baseline when establishing treatment goals.			
Comments:					
UnitedHealthcare Administrative Guide	**12**	For clients 12 years and older, a screening is in evidence of use or exposure to alcohol, nicotine and/or illicit drugs.			
Comments:					
UnitedHealthcare Administrative Guide	**13**	In the assessment there is evidence of a screening for possible sexualized behavior.			
Comments:					

Initial assessment			Y	N	NA
UnitedHealthcare Administrative Guide	**14**	The initial assessment screens for any current behavioral health conditions.			
Comments:					
UnitedHealthcare Administrative Guide	**15**	The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.			
Comments:					
UnitedHealthcare Administrative Guide	**16**	The initial assessment screens for any current medical conditions.			
Comments:					
UnitedHealthcare Administrative Guide	**17**	The medical treatment history includes the following information: known medical conditions, dates and providers of previous treatment, current treating clinicians, and current therapeutic interventions and responses.			
Comments:					
UnitedHealthcare Administrative Guide	**18**	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.			
Comments:					
UnitedHealthcare Administrative Guide	**19**	The record includes a thorough assessment of targeted risk behaviors, including harm to self or others.			

Initial assessment			Y	N	NA
Comments:					
UnitedHealthcare Administrative Guide	**20**	The record includes a history of any previous services received, for behavioral health or other intensive autism-related services, including dates of service.			
Comments:					
UnitedHealthcare Administrative Guide	**21**	The behavioral health treatment history includes family history information.			
Comments:					
UnitedHealthcare Administrative Guide	**22**	The medical treatment history includes family history information.			
Comments:					
UnitedHealthcare Administrative Guide	**23**	When appropriate, there is evidence of an IEP in the record or documentation of other school-based interventions.			
Comments:					
UnitedHealthcare Administrative Guide	**24**	The assessment documents the spiritual variables that may impact treatment.			
Comments:					
UnitedHealthcare Administrative Guide	**25**	The assessment documents the cultural variables that may impact treatment			

Initial assessment			Y	N	NA
Comments:					
UnitedHealthcare Administrative Guide	**26**	An educational assessment appropriate to the age and level of care is documented.			
Comments:					
UnitedHealthcare Administrative Guide	**27**	The record documents the presence or absence of relevant legal issues of the client and/or family.			
Comments:					
UnitedHealthcare Administrative Guide	**28**	There is documentation that the client and/or family was asked about community resources (support groups, social services, school-based services, other social supports) that they are currently utilizing.			
Comments:					
Level of Care Guidelines	**29**	Each record includes evidence of a practical focus on establishing small units of behavior, which build towards larger, more significant changes in functioning related to improved health and levels of independence.			
Comments:					
Level of Care Guidelines	**30**	There is evidence of collection, quantification and analysis of direct observational data on behavioral targets during treatment and follow-up to maximize and maintain progress toward treatment goals.			
Comments:					

Initial assessment			Y	N	NA
Level of Care Guidelines	**31**	There is evidence of efforts to design, establish and manage the treatment environment(s) in order to minimize problem behavior(s) and maximize rate of improvement.			
Comments:					
Service planning			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	**32**	There is evidence of the use of a carefully constructed, individualized and detailed behavior analytic treatment plan that utilizes reinforcement and other behavior analytic principles.			
Comments:					
UnitedHealthcare Administrative Guide	**33**	The service plan is consistent with diagnosis and has objective and measurable short- and long-term goals.			
Comments:					
UnitedHealthcare Administrative Guide	**34**	The service plan is reviewed and updated with the patient at regular intervals.			
Comments:					
UnitedHealthcare Administrative Guide	**35**	The service plan shows evidence of moving toward discharge.			
Comments:					

Initial assessment			Y	N	NA
UnitedHealthcare Administrative Guide	**36**	There is evidence that the service plan is reviewed on a regular basis.			
Comments:					
Progress notes			**Y**	**N**	**NA**
Level of Care Guidelines	**37**	There is evidence in the progress notes of an emphasis on ongoing and frequent direct assessment, analysis and adjustments to the treatment plan (by the behavior analyst) based on client progress as determined by observations and objective data analysis.			
Comments:					
Level of Care Guidelines	**38**	There is evidence in the progress notes of the use of treatment protocols that are implemented repeatedly, frequently and consistently across environments until the client can function independently in multiple situations.			
Comments:					
UnitedHealthcare Administrative Guide	**39**	Daily notes measure patient response to intervention in specific programs.			
Comments:					
UnitedHealthcare Administrative Guide	**40**	There is evidence of patient response to interventions related to targeted behaviors.			
Comments:					

Progress notes			Y	N	NA
UnitedHealthcare Administrative Guide	**41**	Documentation of the Place of Service is in the service note.			
Comments:					
UnitedHealthcare Administrative Guide	**42**	It is clear in the daily notes who rendered the services.			
Comments:					
UnitedHealthcare Administrative Guide	**43**	The length of service (including start and stop time) is clearly documented in the service note.			
Comments:					
UnitedHealthcare Administrative Guide	**44**	It is clear in the service notes of the monitoring and addressing targeted risk behaviors.			
Comments:					
UnitedHealthcare Administrative Guide	**45**	There is evidence of notes documenting communications with parents/guardians.			
Comments:					
Level of Care Guidelines	**46**	There is evidence of notes documenting direct support and training of family individuals and other involved professionals to promote optimal functioning and promote generalization and maintenance of behavioral improvements.			
Comments:					

Progress notes			Y	N	NA
UnitedHealthcare Administrative Guide	**47**	There is documentation of who is in attendance at the session (parents, other children, BCBA, etc.).			
Comments:					
UnitedHealthcare Administrative Guide	**48**	The record, including the service plan, reflects discharge planning.			
Comments:					
Level of Care Guidelines	**49**	There is evidence of regular direct observation/supervision by a behavior analyst with expertise and formal training in ABA for the treatment of ASD.			
Comments:					
UnitedHealthcare Administrative Guide	**50**	There is evidence of specific service notes of supervision/direct observation in the record.			
Comments:					
Coordination of care			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	**51**	The client has a medical primary care provider (PCP). **This is a non-scored question.**			
Comments:					

Coordination of care			Y	N	NA
UnitedHealthcare Administrative Guide	**52**	The record documents that the client was asked whether they have a PCP (**Y or N only).**			
Comments:					
UnitedHealthcare Administrative Guide	**53**	If the client has a PCP, there is documentation that communication/collaboration occurred.			
Comments:					
UnitedHealthcare Administrative Guide	**54**	If the client has a PCP, there is documentation that the client/guardian refused consent for the release of information to the PCP.			
Comments:					
UnitedHealthcare Administrative Guide	**55**	The client is being seen by another behavioral health clinician (e.g., psychiatrist and social worker, psychologist and substance abuse counselor). **This is a non-scored question.**			
Comments:					
UnitedHealthcare Administrative Guide	**56**	The record documents that the client was asked whether they are being seen by another behavioral health clinician (**Y or N only).**			
Comments:					
UnitedHealthcare Administrative Guide	**57**	If the client is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.			
Comments:					

Coordination of care			Y	N	NA
UnitedHealthcare Administrative Guide	**58**	If the client is being seen by another behavioral health clinician, there is documentation that the client/guardian refused consent for the release of information to the behavioral health clinician.			
Comments:					
Discharge and transfer			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	**59**	The client was transferred/discharged to another clinician or program. **This is a non-scored question.**			
Comments:					
UnitedHealthcare Administrative Guide	**60**	If the client was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
Comments:					
UnitedHealthcare Administrative Guide	**61**	If the client was transferred/discharged to another clinician or program, there is documentation that the client/guardian refused consent for release of information to the receiving clinician/program.			
Comments:					
UnitedHealthcare Administrative Guide	**62**	Prompt referrals to the appropriate level of care are documented when client cannot be safely treated at their current level of care secondary to homicidal or suicidal risk or an inability to conduct activities of daily living.			
Comments:					

Discharge and transfer			Y	N	NA
UnitedHealthcare Administrative Guide	**63**	The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.-			
Comments:					
UnitedHealthcare Administrative Guide	**64**	The discharge/aftercare/safety plan describes specific follow-up activities.			
Comments:					
UnitedHealthcare Administrative Guide	**65**	Clinical records are completed within 30 days following discharge.			
Comments:					

UnitedHealthcare Community Plan – Provider Performance

Applied Behavioral Analysis Agency Site Tool

Facility name: _____

Reviewer name: _____

Date of facility review: _____

Rating scale: NA = Not applicable Y = Yes N = No			Y	N	NA
Environment of care					
NCQA	**1**	The facility location is easily identifiable from the street.			
Comments:					
NCQA	**2**	The furnishings and décor are appropriately professional, and reasonably neat and clean.			
Comments:					
NCQA	**3**	The exits are well marked and free of obstruction.			
Comments:					
NCQA	**4**	There are fire extinguishers in the facility or there is a fire suppression system.			
Comments:					

Environment of care			Y	N	NA
NCQA	**5**	The facility has parking for handicapped vehicles.			
Comments:					
NCQA	**6**	The office has a ramp allowing entrance into the building.			
Comments:					
NCQA	**7**	The facility has wide doorways for wheelchair access.			
Comments:					
NCQA	**8**	The facility has handicap-accessible restroom(s).			
Comments:					
NCQA	**9**	If the facility is not handicap accessible, the program staff screen for handicap needs prior to the first session and refer patients out as needed.			
Comments:					
NCQA	**10**	There is a fire safety plan.			
Comments:					
NCQA	**11**	There is evidence of compliance with fire safety procedures/regulations, including inspection by the fire department/marshal.			
Comments:					

Policies and procedures			Y	N	NA
NCQA	**12**	There is a policy addressing safety and security appropriate to where services are rendered.			
Comments:					
NCQA	**13**	There is a policy and/or procedure for dealing with life-threatening emergencies.			
Comments:					
NCQA	**14**	There is a disaster plan.			
Comments:					
NCQA	**15**	There is a policy and procedure about patient rights, responsibilities and ethics.			
Comments:					
NCQA	**16**	Patient rights, responsibilities and involvement in care are posted in waiting areas and patient care areas.			
Comments:					
NCQA	**17**	There is a policy and procedure about patient involvement in care and services.			
Comments:					
NCQA	**18**	There is a policy and procedure about reasonable access to care.			
Comments:					

Policies and procedures			Y	N	NA
NCQA	**19**	There is a policy and procedure about family involvement in patient care.			
Comments:					
NCQA	**20**	There is a policy addressing control of hazardous materials and wastes, including management of any spills of bodily fluids. (This question applies to all facilities.)			
Comments:					
NCQA	**21**	There is a policy and procedure regarding infection control at the facility, which includes written protocols for communication with local public health authorities.			
Comments:					
NCQA	**22**	The initial assessment form includes a screening for infectious diseases.			
Comments:					
NCQA	**23**	There are written protocols for the treatment of patients with infectious diseases.			
Comments:					
NCQA	**24**	There is a policy and procedure about confidentiality.			
Comments:					

Policies and procedures			Y	N	NA
NCQA	**25**	There is a policy and procedure about the limits, use and protections related to the use of portable electronic media to communicate with patients.			
Comments:					
NCQA	**26**	There is a Performance Improvement Program in place for the program.			
Comments:					
NCQA	**27**	There is a policy/written criteria addressing sentinel events to include identifying opportunities for improvement and implementing corrective action when indicated.			
Comments:		Sentinel events are defined as a serious, unexpected occurrence involving an individual that is believed to represent a possible quality of care issue on the part of the practitioner/facility providing services, which has, or may have, deleterious effects on the individual, including death or serious disability, that occurs during the course of a member receiving behavioral health treatment.			
NCQA	**28**	There is a policy and procedure about informed consent for patients.			
Comments:					
BACB	**29**	All services are provided under the supervision of a board-certified behavior analyst (BCBA) or a licensed mental health professional with training/experience in the treatment of autism spectrum disorders (ASD).			
Comments:					

Policies and procedures			Y	N	NA
BACB	**30**	Each client/family will be assigned to a treatment team (BCBA and paraprofessionals or licensed mental health professional and paraprofessionals).			
Comments:					
Administrative Guidelines	**31**	If the agency does not complete the assessment that results in an ASD diagnosis, the agency must request a copy of that assessment from the provider who completed it. The assessment will be placed in the treatment record, so it is accessible to all staff working with the client and family.			
Comments:					
Administrative Guidelines	**32**	The BCBA or licensed mental health professional will complete an assessment of the client that will be used to develop the treatment/behavioral plan.			
Comments:					
Administrative Guidelines	**33**	The BCBA or licensed mental health professional will develop the treatment/behavior plan and make any updates/changes to that plan.			
Comments:					
Administrative Guidelines	**34**	The treatment/behavior plan will include objective and measurable goals.			
Comments:					
Administrative Guidelines	**35**	The treatment/behavior plan will include baseline and mastery criteria for all goals.			

Policies and procedures			Y	N	NA
Comments:					
BACB	**36**	The direct (one to one) services to the clients and families are provided by paraprofessionals or tutors who are supervised by the BCBA or licensed mental health professional. Score as NA for providers who do not employ paraprofessionals or tutors.			
Comments:					
Administrative Guidelines	**37**	The paraprofessional or tutor will carry out the treatment/behavior plan. Score as NA for providers who do not employ paraprofessionals or tutors.			
Comments:					
Administrative Guidelines	**38**	There is a protocol in place describing family involvement in care; it is clear to the clients and families that family involvement must occur as part of treatment.			
Comments:					
Administrative Guidelines	**39**	There is a policy/written protocol regarding how the agency will make referrals for any services they do not provide. This includes how they will identify the services that are needed and how referrals will be facilitated.			
Comments:					
Administrative Guidelines	**40**	For all services that are rendered, there is written criteria for admission and discharge to services.			
Comments:					

Policies and procedures			Y	N	NA
Administrative Guidelines	41	There is criteria for transitioning individuals to a different level of care or different intensity of services.			
Comments:					
Continuum of care			**Y**	**N**	**NA**
Administrative Guidelines	42	There is a policy/written criteria about expectations for treatment at each level of care, including criteria for transitioning to another level of care, or at the time of their discharge.			
Comments:					
Administrative Guidelines	43	There is a policy/written criteria about expectations for coordinating care with medical and other behavioral health treating providers.			
Comments:					
Human resources			**Y**	**N**	**NA**
Administrative Guidelines	44	Personnel files include: resume, background checks, reference check, job description, license and annual evaluations.			
Comments:					
Administrative Guidelines	45	There is evidence of ongoing assessment of staff competency through performance evaluations and training.			
Comments:					

Human resources			Y	N	NA
Administrative Guidelines	**46**	There is a policy/written criteria addressing staff supervision.			
Comments:					
Administrative Guidelines	**47**	Job descriptions list essential knowledge and skills consistent with the work to be completed.			
Comments:					
Administrative Guidelines	**48**	The facility has a written process in place regarding the pre-screening of direct care staff background prior to hiring.			
Comments:					
Administrative Guidelines	**49**	The facility has a written process in place to credential its practitioners.			
Comments:					
Administrative Guidelines	**50**	A sample of the practitioners' employee/credentialing files were reviewed and the files contained documentation of credentialing consistent with facility policy.			
Comments:					
Administrative Guidelines	**51**	There is evidence of a criminal background check for each staff individual.			
Comments:					

Human resources			Y	N	NA
Administrative Guidelines	**52**	When applicable, there is evidence of verification of any licensure or certification the staff individual holds.			
Comments:					
Administrative Guidelines	**53**	**There are distinct job descriptions for the different types of providers at the agency.**			
Comments:					
Administrative Guidelines	**54**	Competency criteria are defined for each job category.			
Comments:					
Administrative Guidelines	**55**	There is evidence of ongoing training for staff to support competency (initial training as well as annual trainings).			
Comments:					
Administrative Guidelines	**56**	All new staff complete required trainings and orientations **prior** to providing any services.			
Comments:					

Direct observation and supervision			Y	N	NA
Administrative Guidelines	**57**	There is a policy addressing both direct clinical observation and supervision.			
Comments:					
Administrative Guidelines	**58**	The clinical supervisor is easily accessible (either in person or by phone) for any concerns or consultations during sessions.			
Comments:					
Administrative Guidelines	**59**	For BCaBAs and paraprofessionals: A minimum of 1 hour of supervision per month for each case the BCaBA or paraprofessional is involved. The maximum hours approved are based on the direct number of hours the individual is receiving: 1 hour for every 10 hours of direct paraprofessional hours being provided, ordinarily not to exceed 8 hours per month.			
Comments:					
Administrative Guidelines	**60**	Direct clinical observation is documented either in the client's file or a supervision log.			
Comments:					
Administrative Guidelines	**61**	The facility/agency has a process in place to ensure the availability of treatment records to the treating clinicians and the patient.			
Comments:					

United Healthcare®

UnitedHealthcare Community Plan – TennCare

Treatment Record Audit Tool

Facility name: _____

Reviewer name: _____

Date of facility review: _____

Rating scale: NA = Not applicable Y = Yes N = No			Y	N	NA
General documentation standards					
UnitedHealthcare Administrative Guide	**1**	Each client has a separate record.			
UnitedHealthcare Administrative Guide	**2**	Each record includes the client's address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.			
UnitedHealthcare Administrative Guide	**3**	All entries in the record include the responsible service provider's name, professional degree and relevant identification number, if applicable, and dated and signed where appropriate.			
UnitedHealthcare Administrative Guide	**4**	The record is clearly legible to someone other than the writer.			
UnitedHealthcare Administrative Guide	**5**	There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the client and/or legal guardian.			

General documentation standards			Y	N	NA
UnitedHealthcare Administrative Guide	**6**	There is documentation that the service provider provides education to client/family about service planning, discharge planning, supportive community services, behavioral health problems and care options.			
UnitedHealthcare Administrative Guide	**7**	There is documentation that the risks of noncompliance with treatment recommendations are discussed with the client and/or family or legal guardian.			
Initial assessment			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	**8**	The reasons for admission or initiation of treatment are indicated.			
UnitedHealthcare Administrative Guide	**9**	A complete clinical case formulation is documented in the record (e.g., primary diagnosis, medical conditions, psychosocial and environmental factors and functional impairments).			
UnitedHealthcare Administrative Guide	**10**	An initial primary treatment diagnosis is present in the record.			
UnitedHealthcare Administrative Guide	**11**	A behavioral health history is in the record.			
UnitedHealthcare Administrative Guide	**12**	A medical history and/or medical assessment (appropriate to the level of care) is in the record.			
UnitedHealthcare Administrative Guide	**13**	Was a current medical condition identified? **This is a non-scored question. (If #14 is N, then #15 and 16 are N/A.)**			

Initial assessment			Y	N	NA
UnitedHealthcare Administrative Guide	**14**	If a medical condition was identified, there is documentation that communication/ collaboration with the treating medical clinician occurred. **This is a non-scored question.**			
UnitedHealthcare Administrative Guide	**15**	If a medical condition was identified, there is documentation that the patient/ guardian refused consent for the release of information to the treating medical clinician. **This is a non-scored question.**			
UnitedHealthcare Administrative Guide	**16**	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.			
UnitedHealthcare Administrative Guide	**17**	A complete mental status exam is in the record, documenting the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory and impulse control.			
UnitedHealthcare Administrative Guide	**18**	The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.			
UnitedHealthcare Administrative Guide	**19**	The medical treatment history includes the following information: known medical conditions, dates and providers of previous treatment, current treating clinicians, and current therapeutic interventions and responses.			
UnitedHealthcare Administrative Guide	**20**	The behavioral health treatment history includes family history information.			
UnitedHealthcare Administrative Guide	**21**	The medical treatment history includes family history information.			

Initial assessment			Y	N	NA
UnitedHealthcare Administrative Guide	**22**	The record documents a risk assessment appropriate to the level of care and population served, which may include the presence or absence of suicidal or homicidal risk, and danger toward self or others.			
UnitedHealthcare Administrative Guide	**23**	The record includes documentation of previous suicidal and homicidal behaviors, including dates, method and lethality, or no history of previous suicidal and homicidal behaviors.			
UnitedHealthcare Administrative Guide	**24**	The behavioral health history includes an assessment of any abuse the individual has experienced, and if the individual has been the perpetrator of abuse.			
UnitedHealthcare Administrative Guide	**25**	For adolescents (aged 12 to 18 years): The assessment documents a sexual behavior history.			
UnitedHealthcare Administrative Guide	**26**	For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic) are documented.			
UnitedHealthcare Administrative Guide	**27**	The initial screen includes an assessment for depression.			
UnitedHealthcare Administrative Guide	**28**	The assessment documents the spiritual variables that may impact treatment.			
Level of Care Guidelines	**29**	The assessment documents the cultural variables that may impact treatment.			

Initial assessment			Y	N	NA
Level of Care Guidelines	**30**	An assessment of the individual's current life status is in the record.			
Level of Care Guidelines	**31**	An initial treatment plan is established at each level of care with goals, treatment priorities and milestones for progress is in the record.			
UnitedHealthcare Administrative Guide	**32**	An educational assessment appropriate to the age and level of care is documented.			
UnitedHealthcare Administrative Guide	**33**	The record documents the presence or absence of relevant legal issues of the individual and/or family.			
UnitedHealthcare Administrative Guide	**34**	There is documentation that the individual was asked about the community resources (support groups, social services, school-based services, other social supports) they are currently utilizing.			
UnitedHealthcare Administrative Guide	**35**	An assessment of the individual's functioning in the domain of living arrangements is in the record.			
UnitedHealthcare Administrative Guide	**36**	An assessment of the individual's functioning in the domain of daily activities (vocational/ educational) is in the record.			
Level of Care Guidelines	**37**	An assessment of the individual's functioning in the domain of social support is in the record.			
Level of Care Guidelines	**38**	An assessment of the individual's functioning in the domain of finances is in the record.			

Initial assessment			Y	N	NA
UnitedHealthcare Administrative Guide	**39**	An assessment of the individual's functioning in the domain of leisure and recreation is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**40**	An assessment of the individual's functioning in the domain of physical health is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**41**	An assessment of the individual's functioning in the domain of emotional and behavioral health is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**42**	There is evidence that the assessment is used in developing the treatment plan and goals.			
Progress notes			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	**43**	For patients 12 and older, a substance abuse screening occurs. Documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications.			
UnitedHealthcare Administrative Guide	**44**	For patients 12 and older, the substance use screening includes documentation of past and present use of nicotine.			

Progress notes			Y	N	NA
UnitedHealthcare Administrative Guide	**45**	If the screening indicates an **active** alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.			
Level of Care Guidelines	**46**	The substance identified as being misused was alcohol. **This is a non-scored question.**			
UnitedHealthcare Administrative Guide	**47**	The substance(s) identified as being misused were substance(s) other than alcohol. **This is a non-scored question.**			
UnitedHealthcare Administrative Guide	**48**	The substance(s) identified as being misused were alcohol and other substance(s). **This is a non-scored question.**			
Treatment planning			**Y**	**N**	**NA**
Level of Care Guidelines	**49**	The individualized treatment/service plan is completed within the first 30 days of admission to behavioral health services.			
UnitedHealthcare Administrative Guide	**50**	The individualized treatment/service plan is based on individual strengths.			
UnitedHealthcare Administrative Guide	**51**	The individualized treatment/service plan is consistent with the assessment and diagnosis.			
UnitedHealthcare Administrative Guide	**52**	The individualized treatment/service plan is updated every 6 months, or more frequently or as clinically indicated, based on the individual's progress toward goals or a significant change in psychiatric symptoms, medical condition or community functioning.			

Treatment planning			Y	N	NA
UnitedHealthcare Administrative Guide	**53**	The individualized treatment/service plan indicates that the individual and/or his/her support system were involved in the development of the treatment goals as well as subsequent reviews of the treatment/service plan.			
UnitedHealthcare Administrative Guide	**54**	There is documentation that the patient or legal guardian has agreed to the individualized treatment/service plan.			
UnitedHealthcare Administrative Guide	**55**	The individualized treatment/service plan documents the duration and intensity of services necessary to promote the recovery and resilience of the patient.			
UnitedHealthcare Administrative Guide	**56**	The individualized treatment/service plan identifies the problems for which the patient is seeking treatment.			
UnitedHealthcare Administrative Guide	**57**	The individualized treatment/service plan has **measurable** objectives to address goals identified.			
UnitedHealthcare Administrative Guide	**58**	The individualized treatment/service plan has target dates for goal attainment.			
UnitedHealthcare Administrative Guide	**59**	The individualized treatment/service plan is updated whenever goals are achieved, or new problems are identified.			
UnitedHealthcare Administrative Guide	**60**	There is at least 1 goal for each service being provided to the patient.			
UnitedHealthcare Administrative Guide	**61**	The documentation supports that the individual receives all care that is included on the individualized treatment/service plan.			

Treatment planning			Y	N	NA
UnitedHealthcare Administrative Guide	**62**	The individualized treatment/service plan identifies staff individuals responsible for each objective.			
UnitedHealthcare Administrative Guide	**63**	The individualized treatment/service plan is signed by the staff individuals who developed the plan and by the primary staff individuals responsible for implementing the treatment/service plan.			
UnitedHealthcare Administrative Guide	**64**	The treatment record includes a crisis prevention/resolution plan appropriate to the current level of care. The plan includes but is not limited to: identification of crisis triggers, steps to prevent, deescalate or defuse crisis situations, phone numbers of those who can assist the individual and the individual's preferred treatment options in a crisis.			
UnitedHealthcare Administrative Guide	**65**	The treatment record includes discharge planning appropriate to the level of care and involving community support systems to include, for example, family, guardian, conservator and outpatient providers.			
UnitedHealthcare Administrative Guide	**66**	The discharge planning includes a description of the follow-up treatment.			
UnitedHealthcare Administrative Guide	**67**	The discharge planning addresses any barriers to recovery.			
UnitedHealthcare Administrative Guide	**68**	The discharge planning documentation shows evidence of ongoing discharge planning throughout treatment.			

Progress notes			Y	N	NA
UnitedHealthcare Administrative Guide	69	The progress notes reflect reassessments when necessary.			
UnitedHealthcare Administrative Guide	70	The progress notes reflect ongoing risk assessments (including but not limited to suicide and homicide) and monitoring of at-risk situations.			
UnitedHealthcare Administrative Guide	71	The progress notes describe individual strengths and limitations in achieving treatment plan goals and objectives.			
UnitedHealthcare Administrative Guide	72	The progress notes describe progress or lack of progress toward treatment plan goals.			
UnitedHealthcare Administrative Guide	73	The progress notes document any referrals made to other clinicians, agencies and/or therapeutic services, when indicated.			
UnitedHealthcare Administrative Guide	74	When appropriate, there is evidence of supervisory oversight of the treatment record. (Records are reviewed on a regular basis with appropriate actions taken.)			

Medication management			Y	N	NA
UnitedHealthcare Administrative Guide	75	There is documentation that indicates the patient understands and consents to the medication used in treatment.			
UnitedHealthcare Administrative Guide	76	For children and adolescents, documentation indicates the responsible family member, or guardian understands and consents to the medication used in treatment.			
UnitedHealthcare Administrative Guide	77	Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.			

Medication management			Y	N	NA
UnitedHealthcare Administrative Guide	**78**	If the patient is on medication, there is evidence of medication monitoring in the treatment record (physicians and nurses).			
UnitedHealthcare Administrative Guide	**79**	When lab work is ordered, there is evidence the lab results were received and reviewed by the prescribing clinician.			
UnitedHealthcare Administrative Guide	**80**	When the patient is on medications, the prescribing clinician documents that the patient was provided with education about the risks, benefits, side effects and alternatives of each medication.			
UnitedHealthcare Administrative Guide	**81**	If the patient was prescribed a controlled substance, there was evidence in the record that the prescriber utilized the Controlled Substances Prescription Monitoring Program (CSPMP) prior to prescribing.			
UnitedHealthcare Administrative Guide	**82**	When a primary care provider is identified, there is evidence the prescriber coordinated care within 14 calendar days after initiation of a new medication. **This is a non-scored question.**			
		If there is evidence of coordination of care outside of 14 calendar days, document how many days after initiation the coordination took place.			
Coordination of care			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	**83**	Does the patient have a medical primary care provider (PCP)? **This is a non-scored question.**			
UnitedHealthcare Administrative Guide	**84**	The record documents that the patient was asked whether they have a PCP. **Y or N only.**			

Coordination of care			Y	N	NA
UnitedHealthcare Administrative Guide	**85**	If the patient has a PCP, there is documentation that communication/collaboration occurred.			
UnitedHealthcare Administrative Guide	**86**	If the patient has a PCP, there is documentation that the patient/guardian refused consent for the release of information to the PCP.			
UnitedHealthcare Administrative Guide	**87**	Is the patient being seen by another behavioral health clinician (e.g., psychiatrist and social worker, psychologist and substance abuse counselor). **This is a non-scored question.**			
UnitedHealthcare Administrative Guide	**88**	The record documents that the patient was asked whether they are being seen by another behavioral health clinician. **Y or N only.**			
UnitedHealthcare Administrative Guide	**89**	If the patient is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.			
UnitedHealthcare Administrative Guide	**90**	If the patient is being seen by another behavioral health clinician, there is documentation that the patient/guardian refused consent for the release of information to the behavioral health clinician.			
Discharge and transfer			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	**91**	At discharge, the record documents any referrals to other clinicians, services, community resources, or wellness and prevention programs.			
Comments:					

Discharge and transfer			Y	N	NA
UnitedHealthcare Administrative Guide	**92**	Was the patient transferred/discharged to another clinician or program? **This is a non-scored question.**			
UnitedHealthcare Administrative Guide	**93**	If the patient was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
UnitedHealthcare Administrative Guide	**94**	If the patient was transferred/discharged to another clinician or program, there is documentation that the patient/guardian refused consent for release of information to the receiving clinician/program.			
UnitedHealthcare Administrative Guide	**95**	Prompt referrals to the appropriate level of care are documented when patients cannot be safely treated at their current level of care secondary to homicidal or suicidal risk or an inability to conduct activities of daily living.			
UnitedHealthcare Administrative Guide	**96**	For all discharged patients, the discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.			
UnitedHealthcare Administrative Guide	**97**	For all discharged patients, the discharge/aftercare/safety plan describes specific follow-up activities.			
UnitedHealthcare Administrative Guide	**98**	For patients, ages 16 years and older, there is documentation that the patient was educated about a Declaration for Mental Health Treatment.			
		NA for acute and RTC providers			
Comments:					

Special status situations, children and adolescents and priority populations			Y	N	NA
UnitedHealthcare Administrative Guide	**99**	There is documentation that the patient was given information to develop a Declaration for Mental Health Treatment if they requested the information.			
		NA for acute and RTC providers			
Comments:					
UnitedHealthcare Administrative Guide	**100**	Each patient who has executed a Declaration of Mental Health Treatment should have a copy of the form in a prominent place within their record.			
		NA for acute and RTC providers			
Comments:					

UnitedHealthcare Community Plan – TennCare

Organizational Site Audit Tool

Facility name: _____

Reviewer name: _____

Date of facility review: _____

Rating scale: NA = Not applicable Y = Yes N = No			Y	N	NA
Environment of care					
UnitedHealthcare Community Plan – TennCare	**1**	The facility location is easily identifiable from the street (may be scored NA in situations where prominent display of the identification of the facility is not appropriate).			
UnitedHealthcare Community Plan – TennCare	**2**	The furnishings and décor are appropriately professional, and reasonably neat and clean.			
UnitedHealthcare Community Plan – TennCare	**3**	The waiting room and patient care areas are of adequate size and reasonably comfortable.			
UnitedHealthcare Community Plan – TennCare	**4**	There are no culturally insensitive or offensive materials posted.			

Environment of care			Y	N	NA
UnitedHealthcare Community Plan – TennCare	**5**	There is a fire safety plan.			
UnitedHealthcare Community Plan – TennCare	**6**	There is evidence of compliance with fire safety procedures/regulations, including inspection by the fire department/marshal.			
UnitedHealthcare Community Plan – TennCare	**7**	The exits are well marked and free of obstruction.			
UnitedHealthcare Community Plan – TennCare	**8**	There are fire extinguishers in the organization or there is a fire suppression system.			
UnitedHealthcare Community Plan – TennCare	**9**	The organization has parking for handicapped vehicles.			
UnitedHealthcare Community Plan – TennCare	**10**	The organization has a ramp allowing entrance into the building.			
UnitedHealthcare Community Plan – TennCare	**11**	The organization has wide doorways for wheelchair access.			

Environment of care			Y	N	NA
UnitedHealthcare Community Plan – TennCare	**12**	The organization has handicap accessible restroom(s).			
UnitedHealthcare Community Plan – TennCare	**13**	If the organization is not handicap accessible, does the program staff screen for handicap needs prior to the first session and refer patients out as needed? (NA if office is ADA compliant)			
Rights and responsibilities			**Y**	**N**	**NA**
UnitedHealthcare Community Plan – TennCare	**14**	Patients are informed that they have a right to refuse to participate in treatment.			
UnitedHealthcare Community Plan – TennCare	**15**	Patients are informed that information about them and their families is protected and kept confidential.			
UnitedHealthcare Community Plan – TennCare	**16**	The computer screen locations do not violate confidentiality.			
UnitedHealthcare Community Plan – TennCare	**17**	The practice site has an established policy/procedure to maintain the confidentiality and safety of treatment records in accordance with any applicable statutes and regulations.			
UnitedHealthcare Community Plan – TennCare	**18**	There is a policy and procedure about the limits, use, and protections related to the use of portable electronic media to communicate with patients, including cellular calls, text messages and email.			

Rights and responsibilities			Y	N	NA
UnitedHealthcare Community Plan – TennCare	**19**	The office has a policy and/or process in place to ensure that members are not discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.			

Safety and security			Y	N	NA
UnitedHealthcare Community Plan – TennCare	**20**	There is a policy addressing safety and security.			
UnitedHealthcare Community Plan – TennCare	**21**	There is a policy and/or procedure for dealing with life threatening emergencies.			
UnitedHealthcare Community Plan – TennCare	**22**	There is a comprehensive disaster plan , including plans for continuation of care when services are disrupted.			
UnitedHealthcare Community Plan – TennCare	**23**	There is a policy addressing control of hazardous materials, cleaning supplies/ chemicals, and wastes.			
UnitedHealthcare Community Plan – TennCare	**24**	There is a policy addressing management of any spills of bodily fluids.			

Safety and security			Y	N	NA
UnitedHealthcare Community Plan – TennCare	**25**	There is a policy/written criteria addressing sentinel events to include identifying opportunities for improvement and implementing corrective action when indicated.			
		Sentinel events are defined as a serious, unexpected occurrence involving a member that is believed to represent a possible quality of care issue on the part of the practitioner/organization providing services, which has, or may have, deleterious effects on the member, including death or serious disability, that occurs during the course of a Member receiving behavioral health treatment.			
Addressing infectious diseases			**Y**	**N**	**NA**
UnitedHealthcare Community Plan – TennCare	**26**	There is a policy and procedure regarding infection control at the organization which includes written protocols for communication with local public health authorities.			
UnitedHealthcare Community Plan – TennCare	**27**	There are written protocols for working with patients with infectious diseases.			
Treatment records			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	**28**	There is a process in place to ensure the availability of treatment records to the treating practitioners.			
UnitedHealthcare Administrative Guide	**29**	For facilities/agencies with Electronic Health Records Only: The organization/agency has an established procedure to maintain a backup copy of all electronic health records.			

Treatment records			Y	N	NA
UnitedHealthcare Administrative Guide	**30**	Medical records are maintained or available at the site where services are rendered.			
UnitedHealthcare Administrative Guide	**31**	Medical records are stored securely, and access is given only to authorized personnel.			
UnitedHealthcare Administrative Guide	**32**	There is an organized system of filing information in the treatment records.			
UnitedHealthcare Administrative Guide	**33**	Confidentiality of records is maintained in accordance with HIPAA and TCA Title 33.			
UnitedHealthcare Administrative Guide	**34**	All individuals are given access to their records, to the extent and in the manner provided by TCA 63-2-101, 63-2-102 and 33-3-104 et seq., and, subject to reasonable charges, may receive copies upon request.			
UnitedHealthcare Administrative Guide	**35**	If records need to be transported to another service location, there is a protocol in place to maintain confidentiality of records throughout the transportation process.			
Complaints			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	**36**	There is a protocol dealing with complaints			
UnitedHealthcare Administrative Guide	**37**	The organization documents that patients/families are informed of methods of resolving complaints.			

Treatment access			Y	N	NA
UnitedHealthcare Administrative Guide	38	There is a written protocol for accommodating patients in a life threatening emergency.			
UnitedHealthcare Administrative Guide	39	There is a written protocol for accommodating an individual who is experiencing an emergency with an appointment within 4 hours of the time the call requesting the service ended.			
UnitedHealthcare Administrative Guide	40	There is evidence of appointment availability for urgent care within 48 hours.			
UnitedHealthcare Administrative Guide	41	There is evidence of appointment availability for a routine office visit within 10 working days.			
UnitedHealthcare Administrative Guide	42	There is evidence of appointment availability for a routine office visit within 10 working days with a prescriber.			
UnitedHealthcare Administrative Guide	43	The clinician makes arrangements for emergency coverage for all patients 24 hours per day/7 days per week. (review how coverage is provided)			
UnitedHealthcare Administrative Guide	44	Information is provided to patients which includes a description of services and goals of care.			
UnitedHealthcare Administrative Guide	45	Information is provided to patients which includes the hours during which care and services are available.			
UnitedHealthcare Administrative Guide	46	Information is provided to patients which includes the costs of care and services to be borne by the patient.			

Treatment access			Y	N	NA
UnitedHealthcare Administrative Guide	47	Information is provided to patients which includes an explanation of the cancellation/ no-show policy.			

Compliance			Y	N	NA
UnitedHealthcare Administrative Guide	48	There is evidence in the policies/written procedures includes an established compliance plan.			
UnitedHealthcare Administrative Guide	49	There is evidence in the policies/written procedures of a current Compliance Committee and Compliance Officer within the organization.			
UnitedHealthcare Administrative Guide	50	There is evidence in the policies/written procedures that the Compliance program is an ongoing process that includes prevention, detection, collaboration and enforcement.			
UnitedHealthcare Administrative Guide	51	There is evidence in the policies/written procedures of effective and well-defined lines of communication.			
UnitedHealthcare Administrative Guide	52	There is evidence in the policies/written procedures that organization conducts ongoing auditing and monitoring of records.			
UnitedHealthcare Administrative Guide	53	There is evidence in the policies/written procedures that organization has a process for reinforcement and/or discipline to address founded quality and administrative issues.			

Patient safety			Y	N	NA
UnitedHealthcare Administrative Guide	54	If the clinician has any animals in the office, are the patients told in advance that there is/are an animal(s) in the office (N/A means the clinician has **no animals** in the office).			

Patient safety			Y	N	NA
UnitedHealthcare Administrative Guide	**55**	Is/are the animal(s) certified pet therapy animal(s)?			
UnitedHealthcare Administrative Guide	**56**	Is/are the animal(s) used as part of the therapeutic process?			
UnitedHealthcare Administrative Guide	**57**	Are medications and samples stored in a locked cabinet in a secure area? **(M.D. and APRNs only)**			
UnitedHealthcare Administrative Guide	**58**	The policy/written criteria for assessment procedures includes the type of care to be provided and the need for any further assessments.			
UnitedHealthcare Administrative Guide	**59**	The policy/written criteria for assessment procedures includes an assessment of current behavioral/emotional functioning (history of emotional, behavioral, and substance abuse problems or treatment), the use of alcohol and other drugs by family and patients, and the patient's maladaptive or problem behaviors.			
UnitedHealthcare Administrative Guide	**60**	The policy/written criteria for assessment procedures includes the presenting problems, along with relevant psychological and social conditions affecting the patient's psychiatric and medical status.			
Administrative Guidelines	**61**	The policy/written criteria for assessment procedures includes the reason(s) for admission or treatment.			

Patient safety			Y	N	NA
UnitedHealthcare Administrative Guide	**62**	The policy/written criteria for assessment procedures includes documentation of the psychiatric and medical history (previous treatment dates, clinician identification, therapeutic interventions and responses, sources of clinical data, relevant family information; and when appropriate, results of laboratory tests, and consultation reports).			
UnitedHealthcare Administrative Guide	**63**	The policy/written criteria for assessment procedures includes evaluation of learning needs and barriers to learning as well as the level of functioning or functional impairment.			
UnitedHealthcare Administrative Guide	**64**	The policy/written criteria for assessment procedures includes the mental status exam (affect, mood, thought content, judgment, insight, attention, concentration, memory, and impulse control).			
UnitedHealthcare Administrative Guide	**65**	The policy/written criteria for assessment procedures includes risk assessments.			
UnitedHealthcare Administrative Guide	**66**	The policy/written criteria for assessment procedures includes identification of community resources used by patients.			
UnitedHealthcare Administrative Guide	**67**	The policy/written criteria for assessment procedures includes evaluation of the extent of the family's participation.			
Administrative Guidelines	**68**	The policy/written criteria for assessment procedures includes a social history, including: vocational, spiritual, cultural, educational, and legal assessments and services (appropriate to the level of care).			

Patient safety			Y	N	NA
UnitedHealthcare Administrative Guide	69	The policy/written criteria for assessment procedures includes the identification and prominent listing of relevant medical conditions.			
UnitedHealthcare Administrative Guide	70	The policy/written criteria for assessment procedures includes the identification of or patient's self-report of infectious and contagious diseases.			
UnitedHealthcare Administrative Guide	71	The policy/written criteria for assessment procedures includes documentation of allergies to medications and other substances.			
UnitedHealthcare Administrative Guide	72	The policy/written criteria for assessment procedures identifies the specific services to be provided to children or adolescents.			
UnitedHealthcare Administrative Guide	73	The policy/written criteria for assessment procedures includes the assessment and treatment of chemical dependency problems.			
UnitedHealthcare Administrative Guide	74	The policy/written criteria for assessment procedures includes use of a diagnostic/ integrated assessment to develop a treatment plan.			
UnitedHealthcare Administrative Guide	75	There is a Quality Improvement Process in place for the program.			
Human resources			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	76	Personnel files include: resume, background checks, reference check, job description, license, and annual evaluations.			

Human resources			Y	N	NA
UnitedHealthcare Administrative Guide	77	Job Descriptions list essential knowledge and skills consistent with the work to be completed.			
UnitedHealthcare Administrative Guide	78	The organization has a written process in place to verify the credentials of its' practitioners.			
UnitedHealthcare Administrative Guide	79	The organization has a written process in place regarding the pre-screening of direct care staff background prior to hiring.			
UnitedHealthcare Administrative Guide	80	A sample of the practitioners' employee/credentialing files were reviewed and the files contained documentation of credentialing consistent with organization policy.			
UnitedHealthcare Administrative Guide	81	There is evidence of on-going assessment of staff competency through performance evaluations and training.			
UnitedHealthcare Administrative Guide	82	There is a policy/written criteria addressing staff supervision.			
UnitedHealthcare Administrative Guide	83	There is a policy/written procedure for providing ongoing education to all staff appropriate to the job description and level of responsibility.			
UnitedHealthcare Administrative Guide	84	For any non-independently licensed or unlicensed staff, direct 1:1 supervision by an appropriate clinician occurs on a regular basis and is documented.			
UnitedHealthcare Administrative Guide	85	The CMHC has a written process in place to monitor licensed clinicians for any Medicare/Medicaid or licensure sanctions. This needs to occur prior to hiring and then on a regular on-going basis.			

24-hour psychiatric residential services			Y	N	NA
UnitedHealthcare Administrative Guide	**86**	**For Residential Treatment Services:** Members who are discharged from the RTF are evaluated for mental health case management services.			
UnitedHealthcare Administrative Guide	**87**	**For Residential Treatment Services:** Members who are discharged from facilities are scheduled for medically necessary behavioral health follow up services within 10 business days.			
EPSDT			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	**88**	Behavioral health providers provide diagnostic and treatment services in accordance with the EPSDT screening and diagnosis findings.			
UnitedHealthcare Administrative Guide	**89**	The contract provider notifies the contractor in the event that a screening reveals the need for other health care services, and the provider is unable to make an appropriate referral for those services.			
UnitedHealthcare Administrative Guide	**90**	In the event the member is under sixteen (16) years of age and their parent(s) or legally appointed representative was unable to accompany the member to the examination, the record contains documentation that the provider **EITHER contacted the member's parent(s) or legally appointed representative** to discuss the findings and inform them of any other necessary health care, diagnostic services, treatment, or other recommended measures for the member **OR notified the MCO** to contact the member's parent(s) or legally appointed representative notifying them of the findings.			

Restraint and seclusion			Y	N	NA
Licensure	**91**	There are policies and procedures for restraint and seclusion.			
Licensure	**92**	Seclusion and restraint are used only in an emergency safety situation, which are defined as unanticipated resident behaviors which places the resident or others at a serious threat of violence or injury if no intervention occurs.			
Licensure	**93**	Seclusion and restraint are not used as coercion, discipline, retaliation, retribution, or as compensation for lack of staff presence or competency.			
Licensure	**94**	There is a policy/written criteria that an order for seclusion and restraint is not written as a standing order or on an as-needed basis.			
Licensure	**95**	All staff are trained on the correct application and safe usage of seclusion or restraint.			
Licensure	**96**	There is a policy/written procedure the use of seclusion or restraint is continuously evaluated and ended at the earliest possible time based on the assessment and evaluation of the resident's condition.			
Licensure	**97**	Seclusion and restraint are never used simultaneously.			
Licensure	**98**	At the time of admission, all residents and, if applicable, their family individuals, are informed about the facility's seclusion and restraint policies and protocols in a language they understand.			

Restraint and seclusion			Y	N	NA
Licensure	**99**	There is a policy/written criteria that a signed acknowledgment indicating an understanding of the seclusion and restraint policy is in each record.			
Licensure	**100**	Information about the State Protection and Advocacy Organization is provided to each resident and, if applicable, their family individuals.			

UnitedHealthcare Community Plan – Provider Performance

Appointment Access Tool

Facility name: _____

Reviewer name: _____

Date of facility review: _____

Rating scale: NA = Not applicable Y = Yes N = No			Y	N	NA
Routine services					
UnitedHealthcare Administrative Guide	**1**	For routine services, the individual requesting a routine appointment was offered the appointment for an intake, therapy or medication management appointment within 10 business days of the request for the service.			
Comments:					
Urgent services					
UnitedHealthcare Administrative Guide	**2**	Face-to-face contact with the individual who was experiencing an urgent need was made within 48 hours of the request for the service.			
Comments:					
Emergency services (mobile crisis teams)					
UnitedHealthcare Administrative Guide	**3**	Face-to-face contact with the individual who was experiencing an emergency was made within 4 hours of the time the call requesting the service ended.			
Comments:					

UnitedHealthcare Community Plan – Behavioral Network Services

Clinical Record Tool – CSU

Facility name: _____

Reviewer name: _____

Patient gender: _____

Patient age: _____

Primary diagnosis: _____

Date of facility review: _____

Rating scale: NA = Not applicable Y = Yes N = No			Y	N	NA
General documentation standards					
UnitedHealthcare Administrative Guide	**1**	Each client has a separate record.			
UnitedHealthcare Administrative Guide	**2**	Each record includes the client's address, employer or school, home and work telephone numbers, including emergency contacts, relationship or legal status and guardianship information, if relevant.			
UnitedHealthcare Administrative Guide	**3**	All entries in the record include the responsible service provider's name, professional degree and relevant identification number, if applicable, and dated and signed (including electronic signature for EMR systems) where appropriate.			
UnitedHealthcare Administrative Guide	**4**	The record is clearly legible to someone other than the writer.			

General documentation standards			Y	N	NA
UnitedHealthcare Administrative Guide	5	There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the client and/or legal guardian.			
UnitedHealthcare Administrative Guide	6	There is documentation that the service provider provides education to client/family about service planning, discharge planning, supportive community services, behavioral health problems and care options.			
UnitedHealthcare Administrative Guide	7	There is documentation that the risks of noncompliance with treatment recommendations are discussed with the client and/or family or legal guardian.			
Individual plan of care			**Y**	**N**	**NA**
Licensure	8	An individual plan of care (IPC) is developed and agreed upon by the individual, staff and family individuals/caregivers/support system, as applicable, based on initial and ongoing assessment of need, designed to resolve immediate psychiatric crisis.			
Licensure	9	The record includes the service recipient's name.			
Licensure	10	The record includes the date of plan development.			
Licensure	11	The record includes standardized diagnostic formulation(s) including, but not limited to, the current DSM or ICD.			
Licensure	12	The record includes problems and strengths of the service recipient to be addressed.			
Licensure	13	The record includes observable and measurable individual objectives related to the specific problems identified.			

Individual plan of care			Y	N	NA
Licensure	**14**	The record includes interventions that address specific objectives, identify staff responsible for interventions and planned frequency.			
Licensure	**15**	The record includes signatures of treatment staff responsible for developing plan, including qualified prescriber.			
Licensure	**16**	The record includes signature of recipient (and or parent/guardian, conservator, legal custodian or attorney-in-fact). Reasons for refusal to sign and/or inability to participate in IPC development must be documented.			
Licensure	**17**	The record includes a projected discharge date and anticipated post-discharge needs including documentation of resources needed in the community.			
Licensure	**18**	The record includes the status of the discharge plans, including availability of resources needed in the community, with revisions as indicated.			
Licensure	**19**	There is evidence the IPC is reviewed daily or upon completion of the stated goals as evidenced by documentation of dated signature(s) of appropriate treatment staff, including qualified prescriber.			
Licensure	**20**	There is evidence the IPC is reviewed daily or upon completion of the stated goals as evidenced by documentation of progress toward each treatment objective, with revisions as indicated.			
Licensure	**21**	There is evidence the IPC is reviewed daily or upon completion of the stated goals as evidenced by documentation of status of discharge plans, including availability of resources needed in the community, with revisions as needed.			

Individual plan of care			Y	N	NA
Licensure	**22**	There is evidence the IPC is reviewed daily or upon completion of the stated goals as evidenced by documentation of a statement by the staff psychiatrist or physician of justification for the level of service(s) needed including an assessment of suitability for treatment in a less restrictive environment.			
UnitedHealthcare Administrative Guide	**23**	The crisis stabilization plan identifies criteria to transition the individual to a higher level of care if indicated.			
Licensure	**24**	The individual record contains intake interview and initial physical assessment.			
Licensure	**25**	There is a signed and dated original Consent for Treatment including documentation of informed consent for the administration of medication, if applicable.			
Licensure	**26**	There is a report of the mental status examination and other mental health assessments, as appropriate.			
Licensure	**27**	Daily progress notes by the qualified prescriber, nurses and other mental health professionals, as applicable are in the record.			
Licensure	**28**	The record contains laboratory and radiology results, if applicable.			
Licensure	**29**	There is documentation of all contacts with external medical and other services.			
Licensure	**30**	There is original documentation of all crisis stabilization service physician medication orders.			

Individual plan of care			Y	N	NA
Licensure	**31**	The record contains a discharge summary with prognosis justified by explanation, documentation of discharge disposition, including aftercare arrangements, if applicable.			
Licensure	**32**	The record contains documentation of significant behavioral events and actions taken by staff.			
Licensure	**33**	The individual is not kept more than 4 days without documentation of approval for extension by TDMHSA.			

UnitedHealthcare Community Plan – Behavioral Network Services

Peer Support Record

Facility name: _____

Reviewer name: _____

Patient gender: _____

Patient age: _____

Date of facility review: _____

Rating scale: NA = Not applicable Y = Yes N = No			Y	N	NA
General documentation standards			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	**1**	Each client has a separate record.			
UnitedHealthcare Administrative Guide	**2**	Each record includes the client's address, employer or school, home and work telephone numbers, including emergency contacts, relationship or legal status and guardianship information, if relevant.			
UnitedHealthcare Administrative Guide	**3**	There is evidence in the consumer's record of an inventory of the consumer's strengths and other resilience factors, such as the consumer's support network.			
UnitedHealthcare Administrative Guide	**4**	The record is clearly legible to someone other than the writer.			

General documentation standards			Y	N	NA
UnitedHealthcare Administrative Guide	5	There is evidence in the consumer's record that the peer specialist conducted an inquiry as to whether the consumer has a WRAP, an advanced directive/Declaration of Mental Health, recovery plan and a plan for managing relapse.			
Coordination of care			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	6	There is evidence in the contact record of the consumer's behavioral health clinician (e.g., psychiatrist, social worker, psychologist, counselor, treatment counselor), including contact information.			
UnitedHealthcare Administrative Guide	7	There is evidence in the contact record that the peer specialist is coordinating care with the behavioral health clinician.			
UnitedHealthcare Administrative Guide	8	There is evidence in the contact record that the consumer was asked whether they have a medical primary care provider (PCP).			
UnitedHealthcare Administrative Guide	9	If the consumer has a PCP, there is documentation that communication/collaboration occurred.			
Recovery plan			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	10	There is evidence in the contact record of a recovery plan, developed by the consumer with support from the specialist as needed.			
UnitedHealthcare Administrative Guide	11	The recovery plan includes a description of the consumer's goals, the time frames for meeting each goal and the steps the consumer wants to take to achieve his/her goals.			
UnitedHealthcare Administrative Guide	12	The recovery plan includes a description of how the consumer will engage in peer support, empowerment activities and other community support services.			

Recovery plan			Y	N	NA
UnitedHealthcare Administrative Guide	**13**	The recovery plan includes the development of a WRAP (if desired by the consumer), an advance directive (if desired by the consumer) and/or plan for managing relapse.			
UnitedHealthcare Administrative Guide	**14**	There is evidence that the peer/family/recovery coach has offered the consumer a range of empowerment tools.			
UnitedHealthcare Administrative Guide	**15**	The contact record shows the peer specialist is helping the consumer work with their providers.			
UnitedHealthcare Administrative Guide	**16**	There is evidence the recovery plan is reviewed at regular intervals.			
Transition planning			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	**17**	If the consumer transitioned from the service, there was evidence the peer specialist coordinated the transition with the consumer's primary behavioral health clinician and other appropriate agencies and/or supports.			
UnitedHealthcare Administrative Guide	**18**	If the consumer was transitioned from the service, there was evidence that the peer specialist provided the consumer with a list of appropriate peer support groups and activities.			

UnitedHealthcare Community Plan – Behavioral Network Services

Clinical Record Tool – Psychosocial Rehabilitation

Facility name: _____

Reviewer name: _____

Patient gender: _____

Patient age: _____

Date of facility review: _____

Rating scale: NA = Not applicable Y = Yes N = No			Y	N	NA
General documentation standards					
UnitedHealthcare Administrative Guide	**1**	Each client has a separate record.			
UnitedHealthcare Administrative Guide	**2**	Each record includes the client's address, employer or school, home and work telephone numbers, including emergency contacts, relationship or legal status and guardianship information, if relevant.			
UnitedHealthcare Administrative Guide	**3**	All entries in the record include the responsible service provider's name, professional degree and relevant identification number, if applicable, and dated and signed (including electronic signature for EMR systems) where appropriate.			
UnitedHealthcare Administrative Guide	**4**	The record is clearly legible to someone other than the writer.			

General documentation standards			Y	N	NA
UnitedHealthcare Administrative Guide	5	There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the client and/or legal guardian.			
UnitedHealthcare Administrative Guide	6	There is documentation that the service provider provides education to client/family about service planning, discharge planning, supportive community services, behavioral health problems and care options.			
UnitedHealthcare Administrative Guide	7	There is documentation that the risks of noncompliance with treatment recommendations are discussed with the client and/or family or legal guardian.			
Comprehensive assessment			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	8	The medical assessment includes relevant family information.			
UnitedHealthcare Administrative Guide	9	An initial primary treatment diagnosis is present in the record.			
UnitedHealthcare Administrative Guide	10	Drug allergies, or lack thereof, and adverse reactions are clearly documented at the initial evaluation.			
UnitedHealthcare Administrative Guide	11	A complete mental status exam is in the record, documenting the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control and risk assessment (including, but not limited to, suicide and homicide) and monitoring of at-risk situations. (This documentation should be included in the information requested from the referring agency.)			

Comprehensive assessment			Y	N	NA
UnitedHealthcare Administrative Guide	**12**	For patients 12 and older, a substance use assessment occurs. Documentation includes past and present use of alcohol and/or illicit drugs and nicotine, as well as prescription and over-the-counter medications.			
UnitedHealthcare Administrative Guide	**13**	An assessment of the individual's functioning in the domain of living arrangements is in the record.			
UnitedHealthcare Administrative Guide	**14**	An assessment of the individual's functioning in the domain of daily activities (vocational/educational) is in the record.			
UnitedHealthcare Administrative Guide	**15**	An assessment of the individual's functioning in the domain of social support is in the record.			
UnitedHealthcare Administrative Guide	**16**	An assessment of the individual's functioning in the domain of finances is in the record.			
UnitedHealthcare Administrative Guide	**17**	An assessment of the individual's functioning in the domain of leisure and recreation is in the record.			
UnitedHealthcare Administrative Guide	**18**	An assessment of the individual's functioning in the domain of physical health is in the record.			
UnitedHealthcare Administrative Guide	**19**	An assessment of the individual's functioning in the domain of emotional and behavioral health is in the record.			

Coordination of care			Y	N	NA
UnitedHealthcare Administrative Guide	**20**	The record documents that the patient was asked whether they are being seen by a medical primary care provider (PCP). **Y or N only**			
UnitedHealthcare Administrative Guide	**21**	The patient has a medical primary care provider (PCP). **This is a non-scored question.**			
UnitedHealthcare Administrative Guide	**22**	The record documents that the patient was asked whether they are being seen by another behavioral health clinician. **Y or N only**			
UnitedHealthcare Administrative Guide	**23**	The patient is being seen by another behavioral health clinician (e.g., psychiatrist and social worker, psychologist and substance abuse counselor). **This is a non-scored question**.			
UnitedHealthcare Administrative Guide	**24**	There is documentation of ongoing communication and coordination of care with the individual's behavioral health provider.			
UnitedHealthcare Administrative Guide	**25**	The psychosocial rehabilitation staff evaluates the individual for other health care needs (physical health, substance abuse or behavioral health) and coordinates referrals with individual's other health care providers.			
UnitedHealthcare Administrative Guide	**26**	The record documents that the individual accepted or declined the referral.			
UnitedHealthcare Administrative Guide	**27**	During the initial session, the clinician requests the individual's written consent to exchange information with all appropriate treating professionals and other relevant programs/agencies.			

Coordination of care			Y	N	NA
UnitedHealthcare Administrative Guide	**28**	Coordination of care is completed at the time of intake.			
UnitedHealthcare Administrative Guide	**29**	There is documentation the provider, within 14 calendar days of the start of the service, initiated contact with other providers who were involved with the individual's treatment prior to admission to the obtain information about the individual's condition and response to each program, with individual's documented consent.			
UnitedHealthcare Administrative Guide	**30**	There is documentation that the provider, within 14 calendar days of the start date of service, contacted agencies and programs, such as the school or court system, with which the individual has been involved to coordinate services when appropriate, with the individual's documented consent.			
UnitedHealthcare Administrative Guide	**31**	There is documented evidence of coordination of care throughout the course of treatment.			
Individualized service plan/documentation			**Y**	**N**	**NA**
TennCare Medical Necessity Criteria	**32**	There is an individualized service plan completed within 14 calendar days of the start date of the program.			
Licensure	**33**	An assessment of the individual's living arrangements was completed prior to development of the individual plan of care.			
Licensure	**34**	An assessment of the individual's vocational/educational status was completed prior to development of the individual plan of care.			

Individualized service plan/documentation			Y	N	NA
Licensure	35	An assessment of the individual's social supports was completed prior to development of the individual plan of care.			
Licensure	36	An assessment of the individual's financial status was completed prior to development of the individual plan of care.			
Licensure	37	An assessment of the individual's basic medical history and current health information was completed prior to development of the individual plan of care.			
Licensure	38	An assessment of the individual's leisure/recreational status was completed prior to development of the individual plan of care.			
Licensure	39	An assessment of the individual's emotional/behavioral status was completed prior to development of the individual plan of care.			
Licensure	40	An assessment of the individual's transportation was completed prior to development of the individual plan of care.			
Licensure	41	An assessment of the individual's medications was completed prior to development of the individual plan of care.			
Licensure	42	An assessment of the individual's history of mental health and alcohol and drug treatment episodes was completed prior to development of the individual plan of care.			
Licensure	43	The individualized service plan is based on individual strengths.			

Individualized service plan/documentation			Y	N	NA
Licensure	**44**	The individualized service plan is consistent with the assessment of needs and goals of the individual.			
TennCare Medical Necessity	**45**	The individualized service plan is reviewed within 3 months of the initial development.			
Licensure	**46**	The individualized service plan is updated at least every 6 months, or more often as clinically appropriate.			
TennCare Medical Necessity	**47**	The individualized service plan shall be developed, negotiated and agreed upon by the individual and/or their natural support systems in face-to-face encounters and shall be used to identify the intervention needs necessary to meet the individual's stated goals.			
Licensure	**48**	The individualized service plan identifies the needs and strengths of the individual that are to be addressed within the particular service/program component.			
TennCare Medical Necessity	**49**	The individualized service plan has short-term and long-term recovery goals that are individualized, achievable and measurable.			
TennCare Medical Necessity Criteria	**50**	The individualized service plan includes evidenced-based approaches and interventions used to support the individual in achieving his/her recovery goals focusing on the following: utilization and enhancement of strengths; illness management; activities of daily living; daily structure including supported employment and/or education-related activities; family and social relationships and how they will participate in the program as clinically indicated; identification of specific interventions to address barriers impeding attainment of recovery goals; and increased community engagement aimed at providing new and ongoing social, educational, cultural and vocational experiences to help restore or strengthen the individual's connection to his/her community.			

Individualized service plan/documentation			Y	N	NA
TennCare Medical Necessity Criteria	**51**	The individualized service plan clearly identifies the service modality including the team individuals responsible for monitoring progress of the services delivered.			
Licensure	**52**	The individualized service plan is signed by the staff individuals who developed the plan and by the primary staff individuals responsible for implementing the service plan.			
Licensure	**53**	The PSR record includes a crisis prevention/resolution plan appropriate to the current level of care. The plan includes, but is not limited to, identification of crisis triggers; steps to prevent, deescalate or defuse crisis situations; phone numbers of those who can assist the individual, and the individual's preferred treatment options in a crisis.			
Licensure	**54**	The discharge planning addresses any barriers to recovery.			
Licensure	**55**	Weekly summary progress notes include the goal of the intervention/service, which must coincide with the current service plan goals.			
Licensure	**56**	Weekly summary progress notes include summary of each intervention/service and the individual's progress and/or response to the intervention/service.			
TennCare Medical Necessity Criteria	**57**	The progress notes reflect ongoing risk assessments (including but not limited to suicide and homicide) and monitoring of at-risk situations.			
TennCare Medical Necessity Criteria	**58**	Documentation reflects that the provider and individual collaborate to formally review the service plan and includes clinical rationale for continuation of services, updated goals and progress made in the program and demonstration of individual's engagement in the program.			
		Note: Services should be related to specific individual short-and long-term goals.			

Individualized service plan/documentation			Y	N	NA
TennCare Medical Necessity	**59**	Progress notes document any referrals to other clinicians, community-based services, community resources or wellness and prevention programs, including coordination of PSR program services with other providers.			
TennCare Medical Necessity	**60**	All entries are dated and signed (including the title of the writer) and include the responsible clinician's name, degree, license, title and relevant identification, if applicable. Signatures may be handwritten or electronic.			

UnitedHealthcare Community Plan – Behavioral Network Services

Supported Housing Record

Facility name: _____

Reviewer name: _____

Patient gender: _____

Patient age: _____

Date of facility review: _____

Rating scale: NA = Not applicable Y = Yes N = No			Y	N	NA
General documentation standards					
UnitedHealthcare Administrative Guide	**1**	Each consumer has a separate record.			
UnitedHealthcare Administrative Guide	**2**	Each record includes the consumer's address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.			
UnitedHealthcare Administrative Guide	**3**	There is evidence in the consumer's record of an inventory of the consumer's strengths and other resilience factors such as the consumer's support network.			
UnitedHealthcare Administrative Guide	**4**	The record is clearly legible to someone other than the writer.			

Comprehensive assessment			Y	N	NA
UnitedHealthcare Administrative Guide	**5**	There is evidence in the contact record of the consumer's behavioral health clinician (e.g. psychiatrist, social worker, psychologist, counselor, treatment counselor), including contact information.			
UnitedHealthcare Administrative Guide	**6**	A behavioral health history including relevant family information is in the record.			
UnitedHealthcare Administrative Guide	**7**	An assessment of the individual's current life status is in the record.			
UnitedHealthcare Administrative Guide	**8**	If a medical condition is identified, the medical assessment includes previous treatment dates, identification of clinicians, interventions and responses and sources of clinical data.			
UnitedHealthcare Administrative Guide	**9**	The medical assessment includes relevant family information.			
UnitedHealthcare Administrative Guide	**10**	An initial primary treatment diagnosis is present in the record.			
UnitedHealthcare Administrative Guide	**11**	Drug allergies or lack thereof and adverse reactions are clearly documented at the initial evaluation.			
UnitedHealthcare Administrative Guide	**12**	A complete mental status exam is in the record, documenting the individual's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control and risk assessment (including but not limited to suicide and homicide) and monitoring of at risk situations.			

Comprehensive assessment			Y	N	NA
UnitedHealthcare Administrative Guide	**13**	For individuals 12 and older, a substance use assessment occurs. Documentation includes past and present use of alcohol and/or illicit drugs and nicotine, as well as prescription and over-the-counter medications.			
UnitedHealthcare Administrative Guide	**14**	An assessment of the individual's functioning in the domain of living arrangements is in the record.			
UnitedHealthcare Administrative Guide	**15**	An assessment of the individual's functioning in the domain of daily activities vocational/educational) is in the record.			
UnitedHealthcare Administrative Guide	**16**	An assessment of the individual's functioning in the domain of social support is in the record.			
UnitedHealthcare Administrative Guide	**17**	An assessment of the individual's functioning in the domain of finances is in the record.			
UnitedHealthcare Administrative Guide	**18**	An assessment of the individual's functioning in the domain of leisure and recreation is in the record.			
UnitedHealthcare Administrative Guide	**19**	An assessment of the individual's functioning in the domain of physical health is in the record.			
UnitedHealthcare Administrative Guide	**20**	An assessment of the individual's functioning in the domain of emotional and behavioral health is in the record.			

Coordination of care			Y	N	NA
UnitedHealthcare Administrative Guide	**21**	The record documents that the individual was asked whether they are being seen by a medical primary care provider (PCP). **Y or N only**			
UnitedHealthcare Administrative Guide	**22**	Does the individual have a medical primary care provider (PCP)? **This is a non-scored question.**			
UnitedHealthcare Administrative Guide	**23**	There is documentation that communication/collaboration occurred with the PCP.			
UnitedHealthcare Administrative Guide	**24**	If a medical condition was identified, there is documentation that communication/ collaboration with the treating medical clinician occurred. If there is a refusal for coordination of care, score as NA. **This is a non-scored question.**			
UnitedHealthcare Administrative Guide	**25**	The record documents that the individual was asked whether they are being seen by another behavioral health clinician. **Y or N only**			
UnitedHealthcare Administrative Guide	**26**	Is the individual being seen by another behavioral health clinician (e.g., psychiatrist and social worker, psychologist and substance abuse counselor). **This is a non-scored question.**			
UnitedHealthcare Administrative Guide	**27**	The record documents that the individual was asked whether they are being seen by a medical primary care provider (PCP). **Y or N only**			
UnitedHealthcare Administrative Guide	**28**	Does the individual have a medical primary care provider (PCP)? **This is a non-scored question.**			

Coordination of care			Y	N	NA
UnitedHealthcare Administrative Guide	**29**	There is documentation that communication/collaboration occurred with the PCP.			
UnitedHealthcare Administrative Guide	**30**	If a medical condition was identified, there is documentation that communication/ collaboration with the treating medical clinician occurred. If there is a refusal for Coordination of Care, score as NA. **This is a non-scored question.**			
UnitedHealthcare Administrative Guide	**31**	The record documents that the individual was asked whether they are being seen by another behavioral health clinician. **Y or N only**			
UnitedHealthcare Administrative Guide	**32**	Is the individual being seen by another behavioral health clinician (e.g., psychiatrist and social worker, psychologist and substance abuse counselor). **This is a non-scored question.**			
UnitedHealthcare Administrative Guide	**33**	There is documentation of ongoing communication and coordination of care with the individual's behavioral health provider.			
UnitedHealthcare Administrative Guide	**34**	Does the housing staff evaluate the individual for other health care needs (physical health, substance abuse or behavioral health) and coordinate referrals with individual's other health care providers.			
UnitedHealthcare Administrative Guide	**35**	The record documents that the individual accepted or declined the referral.			
UnitedHealthcare Administrative Guide	**36**	During the initial session, the clinician requests the individual's written consent to exchange information with all appropriate treating professionals.			

Coordination of care			Y	N	NA
UnitedHealthcare Administrative Guide	**37**	Coordination of care is completed at the time of intake.			
UnitedHealthcare Administrative Guide	**38**	There is documented evidence of coordination of care throughout the course of treatment.			
UnitedHealthcare Administrative Guide	**39**	There is documentation showing that within 30 days of admission the provider assisted the individual in obtaining a physical exam to address routine screenings and any specialty care that may be necessary.			
Individualized care/transition plan			**Y**	**N**	**NA**
UnitedHealthcare Administrative Guide	**40**	There is a separate, individualized transitional/housing plan completed within the first 30 days of admission to the supported housing facility.			
UnitedHealthcare Administrative Guide	**41**	An assessment of the individual's strengths is in the record.			
UnitedHealthcare Administrative Guide	**42**	An assessment of the individual's personal goals is in the record.			
UnitedHealthcare Administrative Guide	**43**	An assessment of the individual's needs is in the record.			
UnitedHealthcare Administrative Guide	**44**	The individualized care/transitional plan is based on individual strengths.			

Individualized care/transition plan			Y	N	NA
UnitedHealthcare Administrative Guide	45	The care/transitional plan is consistent with the assessment of needs and goals of the individual.			
UnitedHealthcare Administrative Guide	46	The care/transitional plan indicates that the individual and/or his/her support system were involved in the development of the plan as well as subsequent reviews of the plan.			
UnitedHealthcare Administrative Guide	47	There is documentation that the individual or legal guardian has agreed to the individualized care/transition plan.			
UnitedHealthcare Administrative Guide	48	The care/transition plan documents the duration and intensity of services necessary to promote the recovery and resilience of the individual.			
UnitedHealthcare Administrative Guide	49	The record clearly documents the 15 hours a week training and is consistent with the targeted behaviors/goals noted on the care/transition plan.			
UnitedHealthcare Administrative Guide	50	If the individual is receiving training services beyond the 15 hours a week at the facility, there is documentation of the justification of the additional services.			
UnitedHealthcare Administrative Guide	51	The care /transition plan identifies the targeted behaviors to be addressed in the supported housing setting.			
UnitedHealthcare Administrative Guide	52	The care/transition plan has specific, concrete, realistic and measurable objectives to address goals identified.			
UnitedHealthcare Administrative Guide	53	The care/transition plan has target dates for goal attainment.			

Individualized care/transition plan			Y	N	NA
UnitedHealthcare Administrative Guide	**54**	The care/transition plan is updated whenever goals are achieved, or new problems are identified.			
UnitedHealthcare Administrative Guide	**55**	The individual is making measurable gains in the specific areas identified on the care/ transition plan to move to a less restrictive environment.			
UnitedHealthcare Administrative Guide	**56**	The care/transition plan identifies staff individuals responsible for each objective.			
Licensure	**57**	The care/transition plan is signed by the staff individuals who developed the plan and by the primary staff individuals responsible for implementing the treatment/ service plan.			
Title 33	**58**	The treatment record includes a crisis prevention/resolution plan appropriate to the current level of care. The plan includes, but is not limited to, identification of crisis triggers; steps to prevent, deescalate or defuse crisis situations; phone numbers of those who can assist the individual and the individual's preferred treatment options in a crisis.			
UnitedHealthcare Administrative Guide	**59**	The treatment record includes discharge planning appropriate to the level of care and involving community support systems to include, for example, family, guardian, conservator and outpatient providers.			
UnitedHealthcare Administrative Guide	**60**	The discharge planning includes a description of the follow-up treatment and the anticipated housing choice for the individual.			
UnitedHealthcare Administrative Guide	**61**	The discharge planning addresses any barriers to recovery.			

Individualized care/transition plan			Y	N	NA
UnitedHealthcare Administrative Guide	**62**	The discharge planning documentation shows evidence of ongoing discharge planning throughout treatment.			
UnitedHealthcare Administrative Guide	**63**	Staff clearly document each time a service recipient self-administers medication or refuses medication. This documentation includes the date, time, medication name, dosage and full name of staff individual monitoring medication administration. This is done for prescription and over-the-counter medications.			
UnitedHealthcare Administrative Guide	**64**	Each record includes documentation of the medications prescribed, when the individual takes or refuses the medicine and the name of the staff individual who observed the individual taking the medication.			
Licensure	**65**	The progress notes include assessment of individual progress with meeting treatment plan goals, including discharge.			
Title 33	**66**	The progress notes reflect reassessments when necessary.			
UnitedHealthcare Administrative Guide	**67**	The progress notes reflect ongoing risk assessments (including, but not limited to, suicide and homicide) and monitoring of at-risk situations.			
UnitedHealthcare Administrative Guide	**68**	The progress notes describe individual strengths and limitations in achieving care/ transition plan goals and objectives.			
UnitedHealthcare Administrative Guide	**69**	The progress notes describe progress or lack of progress toward care/transition plan goals.			

Continuum of care and discharge			Y	N	NA
UnitedHealthcare Administrative Guide	**70**	The record documents any referrals to other clinicians, services, community resources or wellness and prevention programs.			
UnitedHealthcare Administrative Guide	**71**	All entries are dated and signed (including the title of the writer) and include the responsible clinician's name, degree, license, title and relevant identification, if applicable. Signatures may be handwritten or electronic.			
Special status situations, adolescents and priority populations			**Y**	**N**	**NA**
Title 33: Chapter 6, Part 10	**72**	There is documentation that the individual was educated about a Declaration for Mental Health Treatment.			
Title 33: Chapter 6, Part 10	**73**	There is documentation that the individual was given information to develop a Declaration for Mental Health Treatment if they requested the information.			
UnitedHealthcare Administrative Guide	**74**	Each individual who has executed a Declaration of Mental Health Treatment should have a copy of the form in a prominent place within their record.			

UnitedHealthcare Community Plan – Provider Performance

Supported Housing Site Tool

Facility name: _____

Reviewer name: _____

Date of facility review: _____

Rating scale: NA = Not applicable Y = Yes N = No			Y	N	NA
Supported housing					
Level of Care Guidelines	**1**	Supported housing facilities are staffed 24 hours a day, 7 days a week with associated mental health staff supports for individuals who require treatment services and supports within a highly structured, safe and secure setting.			
Comments:					
Licensure	**2**	The individual is not required to leave the residence during the day/evening as a condition of admittance or continued stay.			
Comments:					
Licensure	**3**	The program has a policy addressing management, storage and disposal of medications.			
Comments:					

Supported housing			Y	N	NA
Licensure	**4**	Drugs must be stored in a locked container that ensures proper conditions of security and sanitation and prevents accessibility to any unauthorized person.			
Comments:					
Licensure	**5**	Discontinued and outdated drugs and containers with worn, illegible or missing labels must be disposed. Include discussion of how medications are disposed.			
Comments:					
Licensure	**6**	All medication errors, drug reactions or suspected overmedication must be reported to the practitioner who prescribed the drug.			
Comments:					
Licensure	**7**	Prescription medications are to be taken only by clients for whom they are prescribed and in accordance with the directions of a prescribing practitioner, as evidenced daily medication logs kept on site by the supportive housing provider.			
Comments:					
Licensure	**8**	There is evidence of compliance with fire safety procedures/regulations, including inspection by the fire department/marshal.			
Comments:					
Licensure	**9**	The exits are well marked and free of obstruction.			
Comments:					

Supported housing			Y	N	NA
Licensure	**10**	If licensed as a supported living facility: During normal waking hours, all facilities must provide at least one (1) direct-care staff person on duty/on site for every sixteen (16) clients present at the facility. During normal sleeping hours, all facilities must provide at least one (1) direct-care staff person on site in each building where clients are housed; and in any building housing more than sixteen (16) clients, facilities must provide one (1) additional, direct-care staff person on-duty/on-site for each additional sixteen (16) clients.			
Comments:					
Licensure	**11**	If licensed as an adult-supported residential facility: During normal waking hours, all facilities must provide at least one (1) direct-care staff person on duty/on site for every twelve (12) clients present at the facility. During normal sleeping hours, all facilities must provide at least one (1) direct-care staff person on site in each building where clients are housed.			
Comments:					
Licensure	**12**	Daily progress notes should be included in the individual record that assess individual progress with meeting treatment plan goals, including discharge.			
Comments:					

Quality Management Opioid Medication-Assisted Treatment Program Quality Assessment

Date: _____

Reviewer name: _____

Practitioner name: _____

Group name: _____

Group tax ID #: _____

Practitioner specialty: _____

Practitioner NPI #: _____

Practitioner ID #: _____

Practitioner address: _____

Practitioner city: _____

Practitioner state: _____

Practitioner ZIP: _____

Practitioner contact name: _____

Practitioner contact phone: _____

Strd #:

Chart #:	1	2	3	4	5	6	7	8	9	10
Member first name:										
Member last name:										
Member DOB:										
Member age:										

Program structure				
Section I: Policy and Procedure		**Yes = 1**	**No = 0**	**Skip = NA, na or N/A**
1	The provider has a defined policy and procedure for conducting a Controlled Substance Monitoring Data (CSMD) review each time and prior to prescribing, dispensing or administering opiates and/or a controlled substance. The policy should also include guidance around documenting the process in each patient's clinical record.			
2	Provider employs, contracts or partners with a behavioral health counselor to provide psychosocial assessment, addiction counseling, individual counseling, group counseling, self-help and recovery support, and therapy for co-occurring disorders. The counselor should be independently licensed, have a master's degree, and if not independently licensed but with a master's degree, they should be supervised by a licensed mental health provider (e.g., LMSW supervised by LCSW).			
3	Provider employs, contracts, partners or shows effort toward engagement with a certified peer recovery specialist (has certification through TDMHSAS) in the community for consumer education, treatment engagement and recovery planning.			
4	Provider employs, contracts or partners with a local care coordination resource. (Members of the provider's own staff may serve as a care coordinator.)			
5	A Diversion Control Plan is in place including a plan for routine and random pill/film counts.			
6	A written plan is in place to address medical emergencies including naloxone on site.			
7	A written plan is in place to address psychiatric emergencies including involuntary hospitalization.			
8	A policy and procedure is in place to request from the patient a consent to release information to ensure continuity of care and address communications with other providers who are treating the member and with member's informal support system.			
9	The provider has a written policy and procedure for conducting routine and random drug screenings.			

Section I: Policy and Procedure		Yes = 1	No = 0	Skip = NA, na or N/A
10	Provider assesses member experience by collecting surveys with the following elements: Support received during treatment initiation; accessibility to 7-day behavioral and/or physical health availability; and ease of pharmacy services for medication-assisted treatment (MAT) and ability to obtain both MAT and psychiatric medications. Surveys may be completed anonymously as long as it has been documented that a survey has been completed.			
TeleMAT				
11	Evidence of a policy or procedure that uses clinical evidence to determine if a member is no longer a good candidate for teleMAT due to specific risk factors (e.g., concern for diversion). TeleMAT data should be collected for informational purposes only and should not be included in scoring.			
12	Evidence of a plan that would outline how a teleMAT provider would handle emergencies that arise via telehealth (e.g., psychiatric emergency, medical emergency, member high-relapse risk). TeleMAT data should be collected for informational purposes only and should not be included in scoring.			
13	If TeleMAT is being utilized by this provider, the platform has been evaluated and meets all necessary standards (e.g., Non-public facing). TeleMAT data should be collected for informational purposes only and should not be included in scoring.			
	Section score			
Member-based assessment				
Section II: Initial assessment		Yes =1	No =0	
14	The provider ensures either by performing it her/himself or by ensuring it is conducted in full or in part by another qualified professional within the system in which she/he is working, the performance and documentation of initial screening for the diagnostic criteria of an opioid use disorder diagnosis as defined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM Code) determining outpatient buprenorphine MAT program is the most appropriate level of care/treatment.			

Section II: Initial assessment		Yes =1 No =0		
15	The provider ensures either by performing it her/himself or by ensuring it is conducted in full or in part by another qualified professional within the system in which she/he is working, a substance use patient evaluation using standardized assessment and evaluation tools within 30 days of treatment initiation.			
16	The provider ensures either by performing it her/himself or by ensuring it is conducted in full or in part by another qualified professional within the system in which she/he is working, a psychiatric patient evaluation using standardized assessment and evaluation tools within 30 days of treatment initiation.			
17	The provider ensures either by performing it her/himself or by ensuring it is conducted in full or in part by another qualified professional within the system in which she/he is working, a full medical history and examination within 30 days of treatment initiation.			
18	There is evidence that the provider has discussed with the member about a referral to a primary care, behavioral health and/or substance abuse specialist.			
19	There is evidence that the patient was trained on the provider's policy concerning involuntary termination of treatment.			
20	A Narcotic or Controlled Substance Agreement (explaining risk/benefit to achieve informed consent) is present in the clinical record.			
	Section score			
Section III: Appointment frequency		**Yes =1 No =0 Skip =NA, na or N/A**		
	Skip standards 21-23 if the patient is in the maintenance phase. Skip standard 22 if patient is not receiving counseling services.			
21	A patient in the induction or stabilization phases of treatment has had: 1. Weekly provider appointment scheduled			
22	2. Where appropriate*, received appropriate counseling sessions at least twice a month;			
23	3. Had one (1) observed drug screen at least weekly			
	*Skip standards 24-26 if the member is either in the induction/stabilization or maintenance phase for **greater than** 1 year, and complete standards 27-29. Skip standard 25 if patient is not receiving counseling services.*			

Section III: Appointment frequency		Yes =1	No =0	Skip =NA, na or N/A
24	A patient in the maintenance phase of treatment in first year has had: 1. Provider appointment at least every two (2) to four (4) weeks;			
25	2. Where appropriate*, received counseling sessions at least monthly;			
26	3. Had an observed random drug screen at least eight (8) times in 12 months of treatment			
	*Skip standards 27–29 if the member is either in the induction/stabilization or maintenance phase for **less than** 1 year. Skip standard 28 if patient is not receiving counseling services.*			
27	A patient in the maintenance phase of treatment for one (1) year or longer has had: 1. Have a scheduled provider appointment at least every two (2) months;			
28	2. Where appropriate*, follow-up counseling sessions discussed and/or considered for member (monthly counseling sessions recommended)			
29	3. Had an observed random drug screen at least four (4) times in 12 months of treatment			
	Section Score			
Section IV: Service delivery		**Yes =1**	**No =0**	**Skip =NA, na or N/A**
30	There is evidence in the clinical record of member receiving training and education on the following topics (Note: These may be documented once with initial establishment of care; training that occurred more than 2 years before audit was completed does NOT meet this criteria): (a) Treatment options, including detoxification, benefits/risks associated with each option;			
31	(b) Risk of neonatal abstinence syndrome for all female patients of childbearing age (ages 15–44);			
32	(c) Prevention and treatment of chronic viral illnesses, such as HIV and hepatitis C;			
33	(d) Therapeutic benefits and adverse effects of treatment medication;			
34	(e) Risks for overdose, and			
35	(f) Overdose prevention and reversal agents			
36	There is evidence that the Controlled Substance Monitoring Database (CSMD) was queried each time and prior to a prescription being ordered (e.g., e-scribed/called in/written).			

Section IV: Service delivery		Yes =1	No =0	Skip =NA, na or N/A
37	A psychosocial assessment was completed by a qualified professional within the patient's treatment team.			
38	An individualized treatment plan was completed within 30 days of treatment initiation.			
	Skip standard 39 if the member was not in treatment for more than 6 months.			
39	Member's individualized treatment plan was reviewed every 6 months.			
40	The medication prescribed for the member reflects the preferred medication of buprenorphine/naloxone combination (as covered by the TennCare formulary) for induction as well as stabilization unless contraindicated and then the buprenorphine monotherapy has been prescribed if contraindicated.			
	Section score			
Section V: Coordination of care		**Yes = 1**	**No = 0**	**Skip = NA, na or N/A**
	Skip standard 41 if patient is in the maintenance phase or no care coordination services were needed or if patient declined/refused consent to release information.			
41	Where appropriate, a patient in the induction or stabilization phases of treatment received care coordination services weekly.			
	Skip standard 42 if patient is in the induction or stabilization phase or if there are no other members of treatment team or if patient declined/refused consent to release information.			
42	Where appropriate, a patient in the maintenance phase of treatment received care coordination services at least monthly.			
	Skip standard 43–45 if not applicable (for example, counseling is in house (43), or MAT provider is a PCP (44)) or if patient declined/refused consent to release information.			
43	Where appropriate, evidence that care coordination with behavioral health counselor or provider took place within 30 days of treatment initiation and at least every 3 months following. This can be with an internal or external provider.			
44	Where appropriate, evidence that care coordination with primary care provider (PCP) took place within 30 days of treatment initiation and at least annually.			
45	Where appropriate, evidence that information was exchanged with specialist/surgeon/and/or OB-GYN (e.g., sent records, requested records, phone call, updates, etc.).			

Section score			
RESULTS			
Program structure score			
Section I			
Member assessment score			
Section II			
Section III			
Section IV			
Section V			
Total overall score			
Pass (80% or greater)/**Fail** (less than 80%)			

Reviewer notes and comments

Instructions: Document reasons for applying a low score to any specific measure.
Document any pertinent concerns and/or improvements provider is currently implementing.

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